Dynamic Chiropractic

BILLING 101

Using the New Medicare ABN

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Question: *Where can I get a copy of the new Medicare Advanced Beneficiary Notice (ABN)? Can you also give me a primer on how to use it? I am getting conflicting information. Do I use it on the first visit? Do I use it to explain nonpayment for exams, X-rays and physical medicine? Is it required to sign on each date of service? Am I required to charge only the Medicare rate when it is maintenance?*

Thank you for the question. It is a lot to unwind, but it is a protocol that is not is complicated as it would appear. Yes, the new form is available and may be downloaded at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN. There are several versions to make use easier. There are English and Spanish versions, as well as large print. There is a print-only PDF version and also a Word version into which you can type directly.

The prior version was due to be updated in March 2020, as that was the expiration date of the old version, but due to COVID, there were delays. The new version is required for use as of Aug. 31, 2020, but I recommend you start using it immediately.

Why Use the ABN?

The reason for and use of the ABN are explained in its title. It is used as a notice to your patient in advance of the service that the service is not covered. For chiropractic providers, the intent is to inform a patient when manipulation of the spine will not be covered by Medicare. This could be because the condition or diagnosis you are treating is not covered by Medicare; or because the services are considered maintenance.

Use of the form allows you to inform the patient that the services are not going to covered and thus, that payment is their responsibility. In this way, the patient can make an informed choice as to whether to proceed with the services you are recommending.

To be compliant for use, the ABN must be reviewed with the beneficiary or his / her representative, and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice.

Using the ABN for Manipulation of the Spine: Do's and Don'ts

For manipulation of the spine, the notice must be strictly adhered to in its use. However, as you asked, it can also be used for services Medicare never covers in a chiropractic setting: currently all services outside of the three spinal manipulation codes, including exams, X-rays and physical medicine services. When the ABN is used in this way, the beneficiary doesn't need to choose an option box or sign the notice.

Some providers find it easier to use the ABN only for spinal manipulation when maintenance and avoid use for excluded services to eliminate the confusion of using the same form for multiple purposes. If you choose this method, however ,be sure the Medicare patient is informed at the initial visit of the limited benefits for chiropractic; and that all services outside of spinal manipulation are not covered by Medicare (and thus the patient's responsibility).

Note: If the patient has a true secondary insurance plan, it may have some benefits payable beyond spinal manipulation, but that does not change the Medicare benefits.

When an ABN is used for spinal manipulation, Medicare is to be notified that an ABN has been utilized by appending the spinal CMT code with modifier GA. This modifier informs Medicare both that the spinal CMT will be denied as not medically necessary or reasonable; and that there is an ABN on file.

In simple terms, this is our way to have Medicare deny the service, but with patient responsibility. Your patient should clearly understand that the services will not be payable by Medicare and they are responsible for payment. The use of GA creates an automatic denial from Medicare, but with patient responsibility.

Using the ABN on an Initial Visit

As to your question about using on the first visit: If you are using the ABN to inform the patient about excluded services, you certainly may do so. However, for spinal manipulation, it is not likely to be necessary unless the initial visit would not be payable as either a non-related diagnosis or maintenance. The latter is not likely.

Most often, an ABN is used when care becomes non-covered due to maintenance, which is often after 4-16 weeks of care, depending on the severity of the secondary neuromusculoskeletal condition being treated. However, it can be used simply if the patient requests "maintenance" care (spinal adjustments) once per week or month when not related to any underlying diagnosis or condition.

The ABN can be used for a period of visits or time frame, but not to exceed one year. *Note:* If the patient has an injury or flare-up during a time covered by the ABN, the ABN is void, as a new condition has occurred. However, another ABN would have to be provided when or if the services become maintenance or non-covered after acute care.

Charging Your Patient When You Have an ABN on File

As far as what you may charge your Medicare patient when there is an ABN on file, for spinal CMT you are not limited to the Medicare rate. Per the *Medicare Claims Processing Manual*, section 50.7.3, "A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule." Therefore, the fee may be your regular rate should you choose. You may also continue to charge the patient the Medicare rate; but in either case, the amount you will charge for the service, per code or visit, must be disclosed on the ABN.

Editor's Note: Submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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